CHAPTER 8
SECTION 10

APPLICATION OF DEDUCTIBLE AND COST-SHARING

1.0. CLAIM ORDER FOR APPLYING DEDUCTIBLE

The outpatient deductible amounts shall be applied as the claims are processed. When claims are adjusted, the contractor shall apply the deductible based upon the date the claim was initially processed, not the date the claim was subsequently adjusted. See the *TRICARE Reimbursement* Manual, *Chapter 2, Section 1*.

2.0. DEDUCTIBLE DOCUMENTATION

Contractors must furnish a deductible certificate or show the status of the deductible on the EOB except on complete denials. For complete denials the contractor does not query any internal or external catastrophic cap and deductible files and is not required to send deductible information or catastrophic cap information on the denial notice. For services in fiscal years included in CDCF, obtain the amount met toward the deductible from the CDCF. When a claim is adjusted, the contractor shall query CDCF and apply deductible and cap as directed by the CDCF query response. Do not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts. For services in prior years, the beneficiary is responsible for attaching documentation of the deductible taken by other contractors. The contractor shall determine from their deductible record, and/or EOB from other contractors submitted by the beneficiary, the amount the contractor has to assess toward the deductible on the current claim. When a beneficiary subsequently documents an excess deductible, the claim will be adjusted by the contractor that took the excess, based on the order in which claims were processed.

3.0. CENTRAL DEDUCTIBLE AND CATASTROPHIC CAP FILE (CDCF)

3.1. For non-network TRICARE claims, cost-share and deductible amounts shall be applied toward the catastrophic cap as the claims are processed for each fiscal year. For TRICARE Prime and TRICARE Extra claims, all beneficiary cost-shares and deductibles specified in the contract shall be applied toward the cap, including nominal copayments for outpatient care. The amount applied toward the cap on the current claim and the family's cumulative total must be reflected on the EOB, except on complete denials. For complete denials the contractor does not query catastrophic cap and deductible files and is not required to send "cap met" information on the denial notice. For fiscal years included in the CDCF, obtain the amount of Catastrophic Loss Protection cap met, from the CDCF. For prior years the contractor is to use their internal catastrophic cap record. The beneficiary is responsible for informing the contractor through submission of EOBs of deductible and cost-shares paid in a different contractor's jurisdiction. The beneficiary must also provide the EOBs to the contractor for credit to be given for fiscal years not maintained on CDCF. The contractor must determine which services are creditable toward the catastrophic cap by

reference to the *TRICARE Reimbursement* Manual, *Chapter 2, Section 2*. When requested by the beneficiary in writing, the current contractor shall verify the amounts paid with the other contractor or CCS contractor, and include the total toward the catastrophic cap. For purposes of catastrophic loss protection, a TRICARE claim must be submitted along with an EOB from other health insurance for the beneficiary to receive credit for any amount paid by other health insurance, even if the OHI paid the bill in total. Once the contractor determines that the maximum individual/family liability is met for the fiscal year, cost-shares and deductibles will no longer apply, and the TRICARE-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program through the end of that fiscal year. Refer to the *TRICARE Reimbursement* Manual, *Chapter 2, Section 2*. If an adjustment changes whether the cap is met or not, all subsequent claims on history must be adjusted to apply or waive cost-shares. Normal double coverage rules remain in effect after the cap has been reached; the beneficiary must submit a claim to his other health insurance before submitting a claim to the contractor.

3.2. When coordination is required between contractors for fiscal years not included in the CDCF, the contractors will exchange family claims history files (hardcopy only) for the fiscal year in question. Each contractor is then responsible for appropriately annotating its own system to ensure that no further deductibles or cost-shares are withheld for the remainder of the fiscal year. Claims requiring adjustment will be determined by merging the family's claims history to determine the exact date on which the cap was met based on the date claims completed processing. Each contractor will then adjust all claims it adjudicated after this date and refund the over withheld cost-share or deductible.

3.3. For treatment of enrollment fees where the catastrophic cap has been met, see Chapter 6, Section 3.

4.0. ADJUSTMENTS AND RECOUPMENTS

If the contractor is required to recoup a benefit payment any deductible amount applied to the claim to be recouped must be adjusted on the CDCF to reflect that amount as an outstanding deductible. If the contractor had a claim cycle in which an extensive number of claims did not have the deductible amount applied as a result of system or administrative errors, the contractor must proceed with recoupment action in accordance with Chapter 11. For example, if the contractor had errors involving multiple claims within the same claims processing cycle, the recoupment procedures at Chapter 11 will be followed. Any other credited deductible amount resulting from an individual claim adjustment will be offset from future claims received for the beneficiary. The government has determined that it is not cost effective to collect any outstanding deductible amounts at the close of the timely filing period.

5.0. CLAIMS WITH NEGOTIATED RATE AGREEMENTS

Under special programs approved by the TMA Director, where there is a negotiated (discounted) rate agreed to by the provider, the cost-share shall be based on the following:

5.1. For non-institutional providers rendering outpatient care, and for institution-based professional providers rendering both inpatient and outpatient care; the cost-share 20% for outpatient care to active duty family members, 25% for care to all others) shall be applied to, after duplicates and non-covered charges are eliminated, the lowest of the billed charge, the

prevailing charge, the maximum allowable prevailing charge (the Medicare Economic Index (MEI) adjusted prevailing), or the negotiated (discounted) charge, after duplicates and non-covered charges are eliminated.

5.2. For institutional providers subject to the DRG-based reimbursement methodology, the cost-share for other than active duty family members shall be the LOWER OF EITHER:

- The single, specific per diem supplied by TMA (*TRICARE Reimbursement* Manual) after the application of the agreed upon discount rate; OR
- Twenty-five percent (25%) of the billed charge.

5.3. For institutional providers subject to the Mental Health per diem payment system (high volume hospitals and units), the cost-share for other than active duty family members shall be 25% of the hospital per diem amount **after** it has been adjusted by the discount.

5.4. For institutional providers subject to the Mental Health per diem payment system (low volume hospitals and units), the cost-share for other than active duty family members shall be the LOWER OF EITHER:

- The fixed daily amount supplied by TMA (*TRICARE Reimbursement* Manual) after the application of the agreed upon discount rate; OR
- Twenty-five percent (25%) of the billed charge.

5.5. For Residential Treatment Centers, the cost-share for other than active duty family members shall be 25% of the TRICARE rate after it has been adjusted by the discount.

5.6. For institutions and for institutional services being reimbursed on the basis of the TRICARE-determined reasonable costs, the cost-share for other than active duty family members shall be 25% of the allowable billed charges **after** it has been adjusted by the discount.

NOTE: For all inpatient care concerning active duty family members, the cost-share shall continue to be either the daily charge or $25 per stay, whichever is higher. There is no change to the requirement for the active duty family member's cost-share to be applied to the institutional charges for inpatient services. If the contractor learns that the participating provider has billed a beneficiary for a greater cost-share amount, based on the provider's usual billed charges, the contractor shall notify the provider that such an action is a violation of the provider's signed agreement.